

**Background:**

- State Policy Activities — TCDD staff will provide an update regarding recent state public policy staff activities. Discussion topics include:
  1. TCDD's Priority Bill List:
    - A. [Community Living Bill Tracking](#)
    - B. [Education — General Bill Tracking](#)
    - C. [Education — Assessment and Accountability Bill Tracking](#)
    - D. [Employment Bill Tracking](#)
    - E. [Guardianship and Alternatives Bill Tracking](#)
  2. Texas Budget Summary — [House and Senate Budget Comparison](#)
  3. HCS and TxHmL Rate Reduction Update — Issue Brief: Protect People with IDD Through Viable Provider Rates.
  4. Insurance Coverage for ECI Services — Strengthen Early Childhood Intervention for Texas Children House Bill 3930
  5. Other Bills of Interest:
    - A. [Americans with Disabilities Act Bill Tracking](#)
    - B. [Healthcare Bill Tracking](#)
    - C. [Housing Bill Tracking](#)
    - D. [Mental Health Bill Tracking](#)
    - E. [Miscellaneous Bill Tracking](#)
    - F. [Service Animals Bill Tracking](#)
    - G. [Transportation Bill Tracking](#)
    - H. [Voting Bill Tracking](#)
- State Supported Living Centers Update — TCDD staff will provide an update regarding recent SSLC issues. Discussion topics include:
  1. Priority SSLC Bill List — [State Supported Living Centers Bill Tracking](#)
  2. Council Member Public Testimony on an SSLC Restructuring Commission — [Public Testimony — Senate Health and Human Services Committee SB 602](#)
- Federal Policy Activities — TCDD staff will provide an update regarding recent federal public policy issues. Discussion topics include:
  1. Medicaid Block Grants — The Outlook for Medicaid in 2017: Facing Cuts, Block Grants or Per Capital Caps?

**Public Policy Committee — Agenda Item 7****Expected Action:**

The Committee will receive updates on these items and may make recommendations for consideration by the Council.

**Council — Agenda Item 11. A.****Expected Action:**

The Council will receive a report on the Public Policy Committee discussion.

## **Protect People with IDD Through Viable Provider Rates**

### **HCS Waiver Program: A Successful Alternative to State Supported Living Centers (SSLCs)**

As demand for high cost institutions grew from the 1950s – 1980s, families and states successfully urged the federal government to authorize the Home and Community Services (HCS) Waiver program and allow states to offer less costly community services. As designed, the HCS program provides flexible services that accommodate changing needs over time, promotes quality of community life and helps families manage the lifelong responsibilities of supporting a loved one with significant disability. The Texas Home Living Waiver (TxHmL) program was added years later to provide mid-level services and serve as a bridge to more comprehensive services.

### **The Stability of the HCS and TxHmL Waiver Programs is in Jeopardy**

As a cost containment measure, HHSC is recommending a 21% rate cut to HCS and TxHmL Community First Choice (CFC) attendant and habilitation services (budget strategies A.3.1 and A.3.4).

HHSC officials indicate this 21% rate cut is justifiable because it equalizes the rate with lower rates in other programs. The lower rates in other programs are known to yield workforce shortages and high turnover. The proposed cuts to these services will have detrimental impact on the quality of care for people with intellectual disabilities and place them at risk of needing higher cost, residential placement.

Of note, the current rate of \$22.41/hour for attendant and habilitation services covers not only direct service worker wages, but other costs, including benefits, mileage, supervisory and quality assurance monitoring activities, recruitment and training costs, and professional liability.

### **Reasons Why the 21% Rate Cut Will Not Achieve Cost Savings**

- The 21% rate cut for HCS and TxHmL attendant and habilitation rates targets a successful, cost effective service that prevents costly institutional care for people with intellectual disabilities;
- Designed to meet the distinct needs of people with intellectual disabilities, the HCS and TxHmL programs have enabled the state to stop building more institutions and substantially reduced the number of people who live out their lives in institutional care;
- The success of the HCS and TxHmL programs depends on a stable, direct services workforce as the means to keep people out of higher cost residential programs;

- Inadequate direct service worker wages lead to higher turnover of direct service workers, lack of continuity of care, higher risk of abuse and neglect, and increased demand on group home or institutional care;
- The reimbursement rate for HCS and TxHmL CFC attendant and habilitation services is deliberately structured to keep turnover rates low and maintain continuity of care: allowing providers to attract workers with the nature, experience, and skills necessary to effectively support people with intellectual disabilities.

## **Why Are Direct Service Workers So Important For People With Intellectual Disabilities?**

### **Vulnerability to Mental Illness**

As cited in the 2015 Texas Statewide Behavioral Health Strategic Plan for Fiscal Years 2017 – 2021 (p. 27), individuals with intellectual disabilities are more vulnerable to mental illness than the general population. Although prevalence estimates vary, with citations as high as 70%, the National Association for the Dually Diagnosed reports that many professionals have adopted an estimate of 30 – 35% prevalence of psychiatric disorders among people with intellectual and developmental disabilities.

### **Vulnerability to Abuse, Neglect and Exploitation**

Additionally, numerous studies that people with intellectual disabilities are at **high risk of abuse, neglect, and exploitation**. A conversation with families, teachers, and other professionals who know and work with people with intellectual disabilities is all it takes to understand the scope of this risk. An individual with an intellectual disability is more likely to be isolated, dependent on a small circle of friends or caregivers, and perceived as an easy target. All of these factors add up to higher vulnerability for physical and sexual abuse. Compounding this challenge is the limited speaking ability that often accompanies an intellectual disability, creating a circumstance in which the individual has no way to talk about, describe, or report abuse.

None of these factors are a surprise to HCS and TxHmL providers who have supported people with intellectual disabilities in community for many years, but **decision-makers may not understand the important connection between a stable workforce, including direct service workers, and the provider's to successfully support a person with an intellectual disability in community**.

In fact, with the detrimental impact on direct service workers, the HHSC recommendation to cut the attendant and habilitation rates in the HCS and TxHmL programs runs counter to the stated goals of the state to more effectively support the unmet mental health needs of individuals with intellectual disabilities.

Data in the table that follows is drawn directly from cost data included in Rider-directed state reports to the Legislature. A review of the data readily depicts the cost effectiveness of the comprehensive HCS Program (All Settings — including residential, host home and CFC supported home living). In 2015 the average monthly cost per person in the HCS Program) was \$3,522.26. The monthly cost per person represents the average payments paid by the state to HCS Providers per person served. That same year, the average monthly cost per person in an SSLC was \$17,637.46.

However, the real story — when it comes to the HHSC recommended 21% attendant and habilitation rate cut to the HCS program — is the fact that in 2005 the average monthly cost (average payments paid by the state to HCS Providers) per person in the HCS Program was \$3,621.08 and in 2015 the average monthly cost was \$3,522.26, a **3% reduction in cost to the state** over this 10 year span.

Defying the trend in rising healthcare costs, the HCS Program is clearly one of the most cost-effective investments the Legislature could make, in large measure due to the creative development of alternatives to group home settings and the important function of direct service workers. Yet this cost effective alternative to expensive institutional care is the very program HHSC recommends cutting.

In the final analysis, HHSC projects this HCS and TxHmL CFC attendant and habilitation rate cut will save the state \$24.2 million GR in payments for this service, but the unintended consequences of this action would place in jeopardy the safety and well-being of people with intellectual disabilities and set the stage for higher demand on more costly residential and institutional care.

**IDD Services by Program: Average Monthly Costs (per person served)<sup>1</sup>**

<b>Number of Enrollees (average monthly) and Rider Number</b>	<b>SSLCs</b>	<b>ICF/IID</b>	<b>HCS All Settings<sup>2</sup></b>	<b>TxHmL</b>
<b>FY2016 Enrollees</b>	3,083	4,984	26,624	6,822
<b>Rider 21 FY 2015 Data</b>	\$17,637.46	\$4,209.81	\$3,522.26	\$913.81
<b>Rider 23 FY 2013 Data</b>	\$14,143.81	\$4,225.45	\$3,472.29	\$872.61
<b>Rider 28 FY 2011 Data</b>	\$13,119.84	\$4,466.49	\$3,465.31	\$678.94
<b>Rider 31 FY 2009 Data</b>	\$9,906.71	\$4,395.76	\$3,443.06	\$594.95
<b>Rider 40 FY 2007 Data</b>	\$343.39	\$137.27	\$105.99	\$14.94
<b>Rider 44 FY 2005 Data</b>	\$9,292.20	\$3,815.58	\$3,621.08	\$281.11

<sup>1</sup> Rider 40 (FY2007) reported daily costs.

<sup>2</sup> HCS All Settings includes costs for persons served across the entire service array (i.e., residential, host home and CFC attendant and habilitation services).

# **Strengthen Early Childhood Intervention for Texas Children**

## **House Bill 3930**

### **Early Childhood Intervention (ECI) Program Is At Risk**

The Early Childhood Intervention (ECI) program provides services to children under age three with disabilities or developmental delays. Services such as physical and speech therapy help children learn to walk and communicate. By intervening as early as possible to increase a child's ability to reach developmental milestones, ECI is extremely efficient, reducing the tax burden on the state and school systems later in life.

This important program for Texas families faces significant pressures, including:

- Underfunding Texas children of all incomes are eligible for ECI based on medical diagnoses or severity of developmental delays. Unlike other states, Texas does not require private insurance companies to cover most ECI services. Consequently, Texas disproportionately relies on State General Revenue and local funds to cover costs of services for Texas children, including those with private insurance.
- Increasing population As the Texas population grows, the ECI program serves an increasing number of children. On average, the program served approximately 1,200 more children per month in FY 2015 than in FY 2012, for a total of 50,634 children receiving comprehensive services in FY 2015.
- Decreasing provider base ECI providers are terminating contracts at an alarming rate due to underfunding and other financial pressures, leaving many families without reliable access to these services.

### **Private insurance offers an opportunity to improve fiscal stability**

As noted in the Legislative Budget Board's 2017 Staff Report, private insurance offers an opportunity to stabilize costs of the ECI program and reduce pressure on state General Revenue funds.

In FY 2015, speech therapy and specialized skills training (training to correct deficits and teach compensatory skills) made up most of the therapies provided by the ECI program. In Texas, private insurance companies do not provide coverage for specialized skills training and most major insurance companies do not typically provide coverage for speech therapy services for children with developmental delays, unless the delay can be linked to a medical diagnosis (rare in such young children). Medicaid Managed Care Organizations, on the other hand, are required to cover almost all such services.



**House Bill 3930 would maximize non-state sources of revenue for the ECI program**  
House Bill 3930 (Representative Rick Miller) seeks to maximize non-state sources of revenue for the ECI program by requiring most private insurance companies to cover certain ECI services, including speech therapy and specialized skills training, when authorized in a child's Individual Family Services Plan (IFSP).

By requiring private insurance companies to cover ECI services under certain circumstances, Texas would join other states, establish equity between private insurance companies and Medicaid Managed Care Organizations, and take an important step toward fiscal stability for an important early intervention program for Texas children.



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## **The Outlook for Medicaid in 2017: Facing Cuts, Block Grants or Per Capital Caps?**

### **What is Medicaid?**

Medicaid is the nation's primary health insurance program for people with disabilities and low-income populations. The program currently covers over 10 million non-elderly people with disabilities.

Medicaid is a lifeline for most people with significant disabilities who generally do not have access to employer-based or other private coverage, have greater medical needs, and often require assistance with activities of daily living throughout their lifetimes. For many people with intellectual and developmental disabilities (I/DD), Medicaid generally is the only source of funds for them to live and work in the community with friends and families and avoid more costly and segregated nursing homes or institutions. Nationwide, state and federal Medicaid together provide over 75% of the funding for services for people with I/DD.

### **How is Medicaid Currently Structured?**

Medicaid is a jointly funded program with matching state and federal funds. The federal government pays for nearly 60 percent of the cost, though the match rate varies from state to state. Under the current structure the federal government has a commitment to help states cover costs, and in turn states are required to provide specific benefits to certain groups of people, including individuals with disabilities.

The federal match varies by state and the rate is based in part on the poverty or economic status of the state's population. The rate ranges from a federal match of 50 percent to a high of up to 74 percent. When a state spends funds on providing eligible beneficiaries with services, then the state is guaranteed reimbursement from the federal Medicaid program at the state match rate. If a state increases its Medicaid spending, the Federal funding will also increase. Within the basic requirements of the program, states have substantial flexibility to administer the program and to add services and additional beneficiary categories.

### **What is a Medicaid Block Grant?**

A block grant is a funding structure that provides states with a set amount of federal money to fund its Medicaid program. A block grant would effectively end the flexible state and federal partnership. States would be responsible for covering the costs beyond the federal allotment. Deep cuts in federal spending on Medicaid and block grants would be a cost shift to already cash strapped states. This may force states to reduce eligibility, limit services and supports, cut reimbursement to providers, or any number of methods to save

money in the Medicaid program. In addition to forcing bad choices, block grants are likely to cause substantial conflict as groups with diverse needs compete for scarce dollars.

The need for health care and long-term services and supports will not disappear if federal spending is reduced. Many states have waiting lists for services, in some states numbering in the tens of thousands. Without the federal investment, these lists would grow, and those receiving supports would be at risk of a cut in benefits.

Federal policy makers would need to make key policy choices that will determine levels of federal financing as well as federal and state requirements around eligibility, benefits, state matching requirements, and beneficiary protections. A block grant would not adjust to increased coverage needs as the result of an aging population or during bad economic times. Block grants would not adjust to changes in health care, drug costs, or emergencies.

### **What is a Medicaid Per Capita Cap?**

Under a Medicaid per capita cap, the federal government would set a limit on how much to reimburse states per enrollee. Unlike a block grant approach, which provides a fixed amount of federal spending regardless of enrollment, payments to states could reflect changes in enrollment. However, a per capita cap model would not account for changes in the costs per enrollee beyond the cost growth limit. To achieve federal savings, the per capita growth amounts would be set below the projected rates of growth. A per capita cap would have a similar effect on the level of funding available to the state as the block grant approach.

### **What is at Stake for People with Intellectual and Developmental Disabilities?**

States will receive less federal support to administer Medicaid if either or both of these approaches are enacted into law. While there is no way to be certain about what states would do if faced with block grants and reduced federal funds, we know there will be real life consequences for people with I/DD, such as:

- Losing home and community-based services and supports. Waiting lists would quickly grow and it could create a crisis for the over 730,000 people with I/DD living with aging caregivers.
- Losing other critical services such as personal care, prescription drugs, and rehabilitative services. If funds become more scarce, states may decide to stop providing these services altogether. Medicaid usually is the only way people can get access to durable medical equipment like wheelchairs or prosthetic devices, as well as assistive technology.
- Being forced into unnecessary institutionalization. States could return to the days of “warehousing” people with disabilities in institutions. Federal quality standards would be diminished or eliminated and states might once again see this as an

acceptable option, finding it easier or more economical to serve people when they are “all together in one place.”

- Shifting the costs to individuals or family members to make up for the federal cuts. The costs of providing health care and long-term services and supports will not go away, but will be shifted to individuals, parents, states, and providers.
- If cost sharing levels are increased, people may be forced to forego lifesaving treatments, therapies, and medical care.
- Losing the entitlement to Medicaid. Currently if a person meets the eligibility requirements (generally poverty, age, and/or disability), he or she is entitled to the services available under the state Medicaid program. People could lose all access to health care services.
- Children will lose valuable screening, services, and therapies if the Early and Periodic Screening, Diagnosis and Treatment benefit is dismantled. Access to these important services enable children to lead healthy and more active lives and continue to live at home with their families.

Be a part of The Arc’s Disability Advocacy Network to fight these cuts to Medicaid — sign up here: <http://cqrcengage.com/thearc/app/register?0&m=10985>

### **Key Block Grant Message Points**

States would likely consider reducing eligibility, limiting services and supports, and/or cutting reimbursement to providers to save money.

It passes the buck to already cash-strapped states.

Waiting lists for services would be worse.

It would not adjust to changes in health care, drug costs, aging of the population, or emergencies.

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